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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:
May/13/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar myelogram with CT

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Neurosurgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[ ] Upheld (Agree)

[X] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male who sustained an injury on xx/xx/xx. The patient developed complaints of pain in the low back radiating to the right lower extremity initially. The patient subsequently developed radiating pain in the left lower extremity. MRI studies of the lumbar spine from 03/04/14 noted anterolisthesis of L4 on L5 and retrolisthesis of L5 on S1. Disc bulging and facet hypertrophy were noted at L4-5 contributing to substantial foraminal and canal stenosis at this level. At L5-S1, there was osteophyte formation and disc bulging contributing to bilateral foraminal stenosis. The central disc extrusion at L5-S1 noted measured 3mm in AP dimension and 4mm laterally. The patient was referred for a neurosurgical consult due to symptoms. The patient was seen on 03/19/14 with complaints of low back pain radiating to the lower extremities with associated weakness and numbness. The patient reported no benefit from anti-inflammatories, muscle relaxers, or analgesics. The patient reported no benefit from 6 weeks of physical therapy. On physical examination, there was loss of lumbar range of motion noted with hypoesthesia present in the right foot. There was an absent right knee reflex as well as right quadriceps weakness 4+/5. Given the failure of non-operative treatment, the recommendation was for lumbar CT myelography to address potential of nerve root compression due to bony architecture. was also requesting a CT myelogram for surgical planning as it was likely that the patient would require an L4-5 lumbar fusion.

The requested CT myelography study was denied by utilization review on 04/02/14 as the patient had not yet been referred to a surgeon or had been recommended for surgical intervention.

The request was again denied by utilization review on 04/18/14 as there were MRI studies

already identifying pathology.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The clinical documentation submitted for review noted the patient had progressing lower extremity symptoms with associated weakness. The patient was evaluated by Dr., a neurosurgeon, who noted weakness in the lower extremities with sensory loss and reflex changes. Based on MRI findings, Dr. did feel that the patient was a potential surgical candidate to include lumbar fusion. Per guidelines, CT myelography is recommended in the stages of surgical planning to evaluate bony pathology and the extent of this pathology may or may not contribute to overall neural compromise. Given the specificity of CT myelography, it is this reviewer's opinion that in this case, the requested study is medically necessary. As such, the prior denials are overturned.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)